United States Army Chaplain Career and School

MINISTRY TO THE DYING PATIENT AND HIS FAMILY IN THE MILITARY COMMUNITY

A Research Paper Submitted to
Fulfill the Requirements of Techniques of Research

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INTRODUCTION

A chaplain's ministry to the dying patient and his family certainly provides a subject which can be expanded to cover many pages of insight, revelation, challenge, and goals for action. Using research material and personal experience to accomplish my goals, I will deal only with the basic issues of: Intimacy with Death, The Art of Dying, and Ministering to the Bereaved Families.

Dying and death are events that happen to each one of us. We may postpone, gain stays, but eventually we all must die. Is it not a form of head in the sand adjustment to neglect one of the essential realities of life, a cheating of ourselves? The critical question is how each one of us relates to the knowledge that death is certain. In every area of the land, in all of history, the idea of death has posed the eternal mystery which is the center of our religious and philosophical patterns of thought. Perhaps this is the forerunner of human anxiety. As human beings, present behavior is dependent not only on past events but even more so by orientation toward future events. When we stop to consider the matter, the idea of the uniqueness and individuality of each one carries with it the realization that we are finite beings. And it is in this face encounter with death that each of us discovers his hunger for immortality. Our study of the meaning of death and dying can enhance our understanding of the individual's behavior and add another path to analysis of life styles.

Man is the only animal that knows death. At one moment we say, death is an appearance and not an end. And the next, death is real and final, is is fantastic to think otherwise. No doctrine of survival, in any case,

escapes the universal fact of death, nor the suffering that goes with it. These two facts remain the data of every theology.[1]

Traditionally the ministry of the Christian pastor to the dying and the bereaved has been anticipated and welcomed with gratitude. As a representative of the community of faith and hope, he was a reminder of a love transcending death. When one confronts American society's tendency to deny death and to isolate the dying and the bereaved, it becomes apparent that the chaplain's presence is still needed. Yet strangely enough, many contemporary chaplain's are defensive about their work in this area. They feel that the medical profession cares for the dying and the funeral director will care for the bereaved.

> Pastoral care of the dying and the bereaved continues an important aspect of the chaplain's work. By understanding the need of the patient and the bereaved, and by a grasp of his own heritage in Christian truth, the chaplain may serve to help break down the barriers that anxiety about death continues to raise.[2]

Our lack of real intimacy with death is not irremediably bad. But it can lead to making too much or too little of death and a healing ministry to the bereaved. I propose to give some personal feelings which may help the chaplain and his community to face the issue of death and dying and, and, which may assist others, in the community, in ministry to the bereaved in a healthy way. Through Life Enrichment Seminars and Family Encounter Groups, using a self study analysis on one's own death, the participants can develop a wholesome aspect to his own life enabling him to have empathy with and for others.

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[1]Herman Feifel, ed., The Meaning of Death (New York: McGraw-Hill Book Company, Inc., 1959), p. xiii.

[2]Liston O. Mills, ed., Perspectives on Death (Nashville: Abingdon Press, 1969), p. 253.

INTIMACY WITH DEATH

The Military Community is a city whose population comes from every segment of our cultural heritage. Who was to live to experience dying and death 25 years or more ago? Some of our reminiscences would give graphic illustrations concerning the death, wake, and funeral of a member of our community. Each would vary according to the custom and cultural traditions of our community. But, over all the story would be the same. When a person was dying, everyone one would know it, even the children. The dying person would be in his home, attended by his family and friends. Many would visit him. At the very moment of death his family, including children, and friends would be present. They would often hear him speak last words to the dying, and then observe the cessation of breathing, relaxation of the body, and a change of skin color. The members of the family would prepare the body for last rites and the burial. Most of the community would attend these rites. Any death upsets the balance of community life, and the attempt to restore harmony begins with the funeral. It is the community that sees the body, carries it to the grave, and buries it. So in a community this final crises of man is known intimately by everyone. There is no easy escape from the consciousness of death.

The contemporary military situation is quite different. Death surrounds us, yet we are not so intimate with it as before. The dying are now to be found in hospitals, not visited at all by casual acquaintances and only occasionally by friends. The final moments of life are rarely observed even by the family. Then the body disappears, not to the home or church for the whole community, but to a funeral home for family and selected friends.

Attendance at the funeral is even smaller. And we no longer see earth thrown back into the hole, let alone do it ourselves. Finally, such things as laying out great meals for all who attend the rites, holding a wake, or hiring a Dixieland band are passing out of popular custom. All this means that the community has been separated from the dying and the dead. Death is all about us, but circumstances do not provide the intimacy which until recent times has been universal.

Man in the present century denies death as never before in the history of mankind. It is difficult for modern man to accept the finality and reality of death. For example, when a man dies the word death is rarely used. The person 'passed away' or has 'departed' but never died. Families spend many dollars, in an attempt to avoid the finality of death, to place the body in a beautiful carved casket lined with silk and equipped with an inner-spring mattress (to provide final comfort and the silk will not chafe the skin, according to a funeral director in Bartonsville, Oklahoma) to make the dead look more peaceful, as if he were taken. The same funeral director, just mentioned, has a slumber room where the dead are sleep in bed, another attempt to deny the reality of death, especially to the family.

As chaplains working with the dying and their families we have a responsibility to help them have a 'good death.' God is reliable. He must climb the steps of uncertainty, processing his feelings, to recognize that every man faces this reality and in his acceptance of this fact know that he can die in peace. In peace furnished by the love of his family and in his hope of a better world to come. But, in order to be of help, we chaplains have to come to a realistic attitude about our own dying. "We also need to understand the emotional dynamics of those who are facing their own deaths or

the death of a loved one."[3]

The results of the present have been to rob life of much of its depth and meaning. The neglect of death has led to an unhealthy and superficial view of health and well-being; the absence of pain, the absence of conflict, and living life as a bloody. "Christ [and] Buddha knew that man's need to come to terms with his own death. And Viktor Frankl says that to ignore the "tragic triad" of pain, death, and guilt is to lay aside the sources from which man has discovered his deepest meanings."[4]

Death does not seem to plumb such depths in us. The tragic murders of John and Robert Kennedy, of Malcolm X and Martin Luther King, shock us, but the do not goad us into a hard look at the "tragic triad" and they do not alter our confidence in science and technology as our salvation. "Some day a cure will come, perhaps before I die," is the inevitable hope of the terminal ill. Thus death for us is neither a troubling fact nor a moral issue. It is merely "the inevitable conclusion of a natural process. . . . It is a fact in a world of facts, and (thus), our lives lose their essence and we must search in vain for our lost selves. . . . to be [re]born again."[5]

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[3]Robert E. Neale, The Art of Dying (New York: Harper and Row, 1973), p. 2.

[4]Robert Fulton, ed., Death and Dying (New York: John Wiley and Sons, 1965), p. 337.

[5]Ibid. p. 338.

THE ART OF DYING

The Christian minister who takes seriously his ministry to dying persons finds little written by his colleagues to assist him in his work. One token of the secularism of our time is that psychologists, psychiatrists, and sociologists are the current sources of our information on the dying person. Despite this fact the impression gained from a reading of this very sensitive and humane material is that the presence of the chaplain with the dying was never more important than it is now. The available materials describe a central tendency of our time to be the denial of death and the isolation of the dying person. They also insist that many dying persons wish to complete their lives, i.e., "to come to some sense of integrity about the meaning of their relationships to others and the commitments they need to make."[6] The chaplain, bearing witness to a love which does not deny either life or death and which transcends both, may be able to stand with the dying person and to participate in their quest.

Perhaps the most important lesson the chaplain can learn about the dying is their fear of isolation and the tendency of American society to segregate them. Dying persons are not so much afraid of death as they are of the process of dying. They fear progressive isolation, and they fear being forced to go it alone.

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[6]Herman Feifel, The Meaning of Death, (New York: McGraw-Hill Book Company, Inc., 1959), p. 125.

Herman Feifel, after commenting on the fatal need of his patients expressed when given an opportunity to share their feelings, says, "there is almost nothing as crushing to a dying patient as to feel that he has been abandoned or rejected."[7]

Dr. Elisabeth Kubler-Ross describes five stages of dying normally experienced by every one. The value in knowing and understanding these various stages will enhance the chaplain's ministry and will enable the dying person to be understood and helped in his difficult days.

The first stage of dying is that of denial. Dr. Kubler-Ross says:

> Denial functions as a buffer after unexpected shocking news, allows the patient to collect himself and with time, mobilize others, less radical defenses. . . . Denial is usually a temporary defense and will soon be replaced by partial acceptance. Maintained denial does not always bring increased distress if it holds out until the end, which I consider a rarity.[8]

The reaction of the patient and the family after being told of a terminal illness may be a temporary state of shock. When the patient and family recover from the initial shock, the process of denial begins with statements like, "No, not me!" "There must be a mistake!" or "I know, the tests were mixed up." While in this stage the patient and family members avoid discussing any details concerning the illness. Words such as, tumor, malignant, cancer, or growth are rarely used. The illness is usually described as a problem, difficulty, or disease. During this stage the family will go from doctor to doctor in search of someone who will confirm the 'horrible mistake.' Some will become withdrawn and isolate themselves for

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[7]Ibid. p. 125.

[8]Elisabeth Kubler-Ross, *On Death and Dying* (New York: The MacMillan Company, 1969), p. 35.

fear that their denial will break down. Interior patterns of the patient may change to overt physical activity in order to manipulate an early release from the hospital.

> Most patients do not use denial as a constant. They may indicate their inability to cope on a realistically any longer. How do we know, then, when a patient does not wish to face it anymore? He may talk about relevant issues as far as his life is concerned, or he may share most important fantasies about death itself or like after death (a denial itself), only to change the topic for us a few minutes, almost contradicting what he said earlier.[9]

As chaplain's working with dying patients we need to be aware of our own needs because we may be hindering a patient from working through the stage of denial. After all, aren't we the representatives of a God who performs miracles of healing? Whether we or the patient believes this, it will be something that we need to face ourselves.

The second stage of dying is anger. Here the statements of denial become questions: "Why me?" "What did I do to deserve this judgement?" Anger is difficult to handle. This is true for the staff as well as the family. Nothing is right as far as the patient is concerned. In this respect Dr. Kubler-Ross says:

> The problem here is that the family often is involved in the patients position and rightly thinks much about where it came from. Maybe we too would be angry if all our life activities were interrupted so prematurely, if all our usefulness as married wife to an unfinished, to be completed by someone else; if we had some hard-earned money ready to enjoy a few years of rest and enjoyment, for travel for pleasure, suddenly to be confronted with the fact that, this is it, for me. What else would we do with our anger, but ask it to all, or the people who are most likely to enjoy all these things.[10]

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[9]Ibid. pp. 36-37

[10]Ibid. p. 45

I became aware of a dying patient's anger during one of my visits with her when she said in a hostile tone, "Where are you going?" I didn't know what she had in mind until I became aware that I was now standing by her bed, not seated as I was soon after I arrived in her room. My standing irritated her. She felt I was in a hurry to leave and she had some things she wanted to discuss with me.

Families can be caught in this anger, not only as recipients but as participants. The anger the family feels can be expressed with grief and tears, or in guilt and shame. Their anger is not always due to their frustrations but can be the result of the fear they have of their own death. The dying family members anger makes their own death more real.

Allowing the patient to be angry is important. If he is respected and understood, given a little extra loving help, time, and opportunity to ventilate, the patient will soon lower his voice and reduce his angry demands. As chaplain's we can be instrumental in helping the staff understand the patient, and as we share their feelings around the patient.

The third stage of dying is bargaining. This is a very subtle stage. The patient, deciding that if he could get his way through anger, will approach God or man in a nice way. It is like a child that first attempts a temper tantrum and then later responds by volunteering to do things it had earlier refused to do.

Dr. Kubler-Ross says of a bargaining patient:

> A patient who is almost pain and tranquilizer free, unable to go home because of her dependence on intravenous pain relief. She had a son who proceeded with the plans for his marriage, as his mother wished. She was very sad at first that she would be unable to attend the wedding. . . . She bargained with God, made all sorts of promises if she could only live long enough to attend the wedding. . . . Through a series of low doses, we were able to teach her self-hypnosis which enabled her to be quite comfortable for several hours. The day preceding the wedding she

> left the hospital an elegant lady. Nobody would have believed her real condition. . . . I wondered what her reaction would be when the time had run out on the man who had bargained. I will never forget the moment when she returned to the hospital. She looked tired and exhausted and before I could say hello, she said, 'Now don't forget I have another man.'[11]

Many and varied commitments are made in order to gain pardon or release from the impending imprisonment of death.

The fourth stage of dying, according to Dr. Kubler-Ross, is depression. Generally the patient experiences two types of depression. The first is that of a loss of physical function or recovery that robs one of some integrity as a person. A female who is married already has considered be a result of a hysterectomy or the removal of a breast because of belonging may feel guilty of unfulfilled goals. Crying and verbalization relative to the loss characterize this depression.

The second type is less an anticipatory depression, not for past losses but the impending loss of life. It is normally a quiet stage.

> When the terminally ill patient can no longer deny his illness, when he is forced to undergo more surgery or hospitalization, when he begins to have pain symptoms or becomes weaker and thinner, he cannot suffer in any manner. His meekness or stoicism, his anger and rage will soon be replaced by a sense of great loss.[12]

During this stage, the patient may sleep a lot more and there may be a very real attempt for isolation. The patient has little to say but enjoys the presence of his loved ones.

> When the depression is the best preparation for the impending loss of all love objects. In order to facilitate the state of acceptance these communications and communicators are not so meaningful. The patient should not be encouraged to look on

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[11]Ibid. p. 73.

[12]Ibid. p. 75.

the sunny side of things, as this would mean he should not contemplate his impending death.[13]

The final stage is that of acceptance. This should never be mistaken for a happy state, it is void of all feelings. Not every patient reaches this stage. Acceptance is readily noticeable in those who do, they are no longer angry or depressed but have an attitude of peace and understanding. The family may interpret this as an act of giving up. They may plead for the patient to fight or hang on. Some would even pick on doctors and the chaplain for a miracle to prolong life, not realizing that at that moment it may be their needs and not the patient's that are being voiced. The family must differentiate between personal needs and the needs of the patient. To be able to give them help without encountering future feelings of guilt because of the patient's death is indeed a challenge.

In summary of this section, let it be noted that the stages presented are not uniform and evident in all patients. Denial and depression can crop up at any time, interspersed with anger, acceptance and bargaining. It is good to understand these stages for to force one patient to pass through all of them would be unrealistic and cruel. The question facing all of us who work with the dying person and his family is, "Whose needs are being met?"

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[13]Ibid. p. 77.

MINISTRY TO THE BEREAVED

The chaplain"s ministry to the bereaved bears much resemblance to his work with the dying. His attitude toward death influences his willingness to be with those who mourn just as it did with the dying. He still must depend on the work of behavioral scientists for insight into the bereaved's special needs. And he encounters the same tendency to separate life and death and to move the bereaved and his grief out the world of life as before. In some respects his task is similar also. Both the dying and the bereaved face separation, the sting of death. But, whereas the dying look at life to prepare for death and the loss of all relationships, the bereaved must look at death and the loss of one relationship in order to be free to live and love again. To assist the bereaved in his essentially painful passage through grief and back to life, the chaplain must have some knowledge of his psychological needs and of his culture's practices in dealing with death. He must also be aware of his own heritage as a minister and of the strength Christian faith and community bring to those who mourn.

The importance of community in such reaffirmation of meaning is obvious. Indeed one of the continuing problems of the bereaved person is that of the devastating effects isolation may have on him. At every point of the grief process the support of friends and chaplain aid in accept his loss and not to despair of love. A final guideline for the chaplain's ministry to the bereaved, then, is a reiteration of the positive effects of a supporting community.

"Community is important to the bereaved because grief and loss are more readily admitted in a group than even he is alone."[14] They are more likely to confess how deeply they hurt when they know that others face that hurt also. Sorrow is more easily expressed when one sees that others share his loss. Group participation in the bereaved's time of loss causes him to lose his self-consciousness. Suddenly it seems all right to feel as he does. He is understood. "It is this feeling of being understood in grief, of not feeling bereft of all relationships that makes it important to encourage honest emotions."[15]

Community support is beneficial also in the affirmation of meaning. Grief and sorrow left to themselves lead to despair. But the community who stands with the bereaved short-circuits despair with affirmations of faith. The group does not permit his sorrow over separation to lead to despair of love, but, rather they point him to the hope of resurrection which is the victory of love. Comfort comes to the bereaved person in the affirmation of his loss and in affirmation of the God whose love transcends that loss.

Finally, the life of the community is important as the bereaved seeks to establish new relationships and to reconstruct life. It gives him room to make 'false starts.' It offers his opportunity to test his new identity. The confidence of the community in him and their affection for him enable him to work out the meanings of his new life. They are, in short, the patient friends who stand with him while he learns to live and love again.

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[14]Edgar Jackson, For the Living (New York: Channel Press, 1963), p. 94.

[15]Ibid. p. 95.

CONCLUSION

Despite contemporary man's attempts to discipline death, it's sting can still be felt. It's force is seen in modern man's frantic effort to have a good time and in his regard of all talk of death as morbid. It's pain is seen in his consignment of those who face death to loneliness. The chaplain who takes his ministry to the dying and to the bereaved seriously finds himself moving against this cultural stream. For he moves on the assumption that the deepest meanings of life are at the point at which the deepest issues are joined. He assumes that it is only by confronting the end of life and the destructive power of death that a man is able to live and to do his daily work in love. These convictions about life did not originate with the chaplain, or any minister. Jesus of Nazareth has taught him that flinching in the face of death and the temptation to despair of love is no new thing.

But Jesus, who is the Christ, has taught him "that neither death, nor life, nor angels, nor principalities, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God."[16]

Because he has heard these words, and because he represents the One who spoke them, the chaplain's ministry to the dying and the bereaved is most important.

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[16]Romans 8:37-39.

APPENDIX A

During a Family Encounter Group or Life Enrichment Seminar, a chaplain could use the following suggested format for one or more meetings. First the community should be alerted to the theme and given the following statement, or one similar, to read beforehand.

To see all medical men and clergymen as authorities on death and dying would be a mistake. Some are deeply devoted to their fellowmen and to God. But many have been poorly trained, have come gradually toward death too frequently and too harshly, and have developed a professional need to deny. These comments are not made to disparage other respective professions. Rather they should serve as a warning to you about this material.

As a resource person in both psychology and religion, the chaplain or doctor may have a stronger need to deny death than you do. Your thoughts and feelings may well be more aroused than his or other professionals. You are advised to argue with the content of this exercise all you can. The whole enterprise in which we are engaging is quite risky, yet it could be the stepstone to a healthy outlook on life, dying and death for you, your family and the community. It can be the motivating impetus to help others in our own community who may have a need to overcome their own anxiety and fears.

After the above statement has been read, or a similar one, ask the persons assembled to take a moment to reflect on their own intimacy with death. What were the circumstances (if encouraged and/or discouraged exposure to death? After a few moments of reflection invite them to answer the questions on the next page.

APPENDIX B

1. Have you ever seen a deceased body? Yes____ No____

2. Have you ever seen an unembalmed body? Yes____ No____

3. Have you ever seen a person die? Yes____ No____

4. How often have you been in a situation in which you seriously thought you might die?
   Never____
   Once or Twice____
   Several Times____
   Many Times____

5. When has a member of your family or a close relative died?
   Recently____
   Over Two Years____
   Over Five Years____
   Never____

6. Is a member of your family or a close relative dying or ill now at the present time? Yes____ No____

7. When did you last attend a funeral or memorial service?
   Recently____
   Over Two Years____
   Over Five Years____
   Never____

8. When you were a child, how was death talked about in your family?
   Openly____
   Cautiously____
   Avoided Question or Child Was Told Not to Ask____
   Never Talked About____
   Cannot Remember____

9. How often do you think about the possibility of your own death?
   Never____
   Seldom____
   Now and Then____
   Frequently____

10. Do you think you make too much or too little of your own death?
    Too Much____
    Too Little____

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